INTERIM REPORT ON OBSTETRICS

TO THE

HEALTH ADVISORY NETWORK

BY THE

TASK FORCE ON WINNIPEG HOSPITALS ROLE DEFINITION

92-07954/

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June 24, 1991

Dear Colleague:

The Winnipeg Hospitals Role Definition Task Force has completed an Interim Report on Obstetrics. This Interim Report was formally received by the Health Advisory Network Steering Committee.

Consistent with the Minister of Health's desire to ensure adequate consultation, the Steering Committee invites input from those affected by the recommendations of the Task Force before it formalizes its own recommendations. A copy of the Interim Report of the Task Force is enclosed for your review and response. Copies have been distributed to Winnipeg hospitals, professional associations and other organizations for comment. Other interested individuals may request a copy of the Interim Report from this office.

The sequence of the consultation process is outlined below:

1) The Interim Report of the Task Force was received by the Steering Committee.

2) The Steering Committee distributes the Interim Report to interested parties in the community for comment.

3) The community responses are to be forwarded to the Task Force for review in September, 1991.

4) The Task Force will submit its final Report to the Steering Committee, taking into account the reactions to the Interim Report.

5) The Steering Committee will review the final report of the Task Force to formulate options and recommendations for consideration by the Minister of Health.

Your written response to the Interim Report of the Task Force should be received on or before September 6, 1991.

Please **send TWENTY (20) copies** of your comments to:

Health Advisory Network
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Yours truly,

Brian Sudmundson for

Arnold Naimark, M.D.
Chair
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Enc.

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HEALTH ADVISORY NETWORK

TASK FORCE ON WINNIPEG HOSPITALS ROLE DEFINITION

PROJECT 1 - REPORT ON OBSTETRICS

The terms of reference, as they relate to obstetrics, require the Task Force to:

1. **RECOMMEND** the future obstetrics role of each Winnipeg hospital,

   BASED ON

   - the current supply, distribution and utilization of obstetrics beds;
   - the supply and distribution of obstetrics beds required by 1996; and
   - a review of, and the implications of, proposals now before Government for program and facilities development.

2. **RECOMMEND** the mechanisms for fostering and ensuring coordination and cooperation among hospitals, and between hospitals and other health care agencies, in program and facilities development and in the acquisition and utilization of major equipment installations.

   BASED ON

   - a review of the current level of cooperation and coordination among hospitals with obstetrics services.

PROCESS

The Task Force adopted a broad consultative process by meeting with all urban obstetrical hospitals and other concerned organizations such as the Faculty of Medicine, the Manitoba Nurses' Union, the Manitoba Association of Registered Nurses and the College of Physicians and Surgeons of Manitoba. Presentations were made by the Research and Planning Directorate of the Department of Health (regarding early obstetrical discharges) and by the Manitoba Bureau of Statistics (regarding Manitoba birth rates). In addition an Ad Hoc Committee on urban obstetrics was formed comprised of representatives from each hospital. It reviewed the forecasts for the number of births and made observations.

CURRENT SUPPLY, DISTRIBUTION AND UTLIZATION OF OBSETRICS BEDS

DELIVERIES

	86/87	87/88	88/89	89/90	Forecast 90/91	Current Capacity
HSC	3,805	3,920	3,978	4,031	4,180	4,000
St. Bon.	4,316	4,295	4,390	4,408	4,400	4,400
Grace	1,247	1,239	1,305	1,402	1,430	2,000
Miser.	870	783	828	922	880	1,400
Victoria	1,494	1,544	1,556	1,526	1,620	2,500
Total	11,732	11,781	12,057	12,289	12,510	14,300

For the two teaching hospitals, HSC and St.Boniface, current capacity is basically current births and does not reflect the overcrowded conditions. Specifically, HSC was designed for 3,500 births and is in generally antiquated facilities and not fully consolidated. St. Boniface is extremely overcrowded and indicated that it would require double the present space to provide for 5,000 births.

FORECAST TO 95/96 - TOTAL FOR WINNIPEG HOSPITALS

	Actual	Bureau Forecast *	Modified Forecast (1)	(2)	(3)
87/88	11,781	11,770			
88/89	12,057	11,951			
89/90	12,289	11,703			
90/91	12,365	11,465	12,510	12,510	12,510
91/92		11,195	12,250	12,510	12,635
92/93		10,895	12,001	12,510	12,761
93/94		10,593	11,718	12,250	12,889
94/95		10,282	11,404	12,001	13,018
95/96		9,978	11,088	11,713	13,148

* The Manitoba Bureau of Statistics forecast adjusted from calendar year to MHSC fiscal year.

The Manitoba Bureau of Statistics forecast was provided to the Task Force in November 1989. Based on that forecast, and to be somewhat conservative considering the variables involved, the Task Force, at the time, assumed 10,500 live births for the 1995/96 year.

As the Bureau forecast was low by 586 for 89/90 and is expected to be low by 1,045 for 90/91, the Task Force prepared three modified forecasts.

(1) Starting with 90/91 at 12,510 and assuming Bureau reductions commence 91/92 instead of 89/90.
(2) Starting with 90/91 at 12,510 and assuming 12,510 for a further two years and Bureau reductions commence 93/94.
(3) Starting with 90/91 at 12,510 and assuming a 1 percent increase per year.

PROGRAMS BEFORE GOVERNMENT FOR PROGRAM AND FACILITIES DEVELOPMENT

1. St. Boniface Hospital Eastside Development obstetric proposal to provide 5,000 annual deliveries.

2. Health Sciences HA Development includes an obstetrics unit for 4,500 annual deliveries.

3. Misericordia plans for a redeveloped obstetrics unit for 1,200 annual deliveries. In April 1989, MHSC agreed to provide an obstetrical anaesthesia funding arrangement for Misericordia conditional upon an incrase in deliveries. The agreement between MHSC and Misericordia provided that the arrangement will be terminated effective March 31, 1992 if annualized deliveries do not reach 1,200 by that date.

4. Victoria and Grace hospitals indicated to the Task Force they have adequate facilities and do not require further development.

TASK FORCE OBSERVATIONS

1. The forecasts for the number of births in 1995/96 are just that - forecasts. A number of factors influence the actual results. They are:

   a) Changes in the fertililty rate. A projected decrease in the number of women of child bearing age suggests that the birth rate should decline but immigration from Asia or Eastern Europe could increase the fertility rate.

   b) The number of women from rural areas coming to Winnipeg to deliver. During the past eight years deliveries in rural hospitals have decreased 9 percent while increasing almost 16 percent in Winnipeg hospitals (excluding Brandon). See Appendix II. This trend appears to be levelling off but could be affected by the other factors.

   c) Proportion of high risk/low risk deliveries. The expansion of fetal assessment could increase the number of high risk rural women delivering at the two teaching hospitals.

   d) It is assumed that therapeutic abortions will continue at the current rate although this could be influenced by future legislation, funding arrangements and the number of physicians providing abortions.

   e) An increase or decrease in the population of Manitoba and Winnipeg. Of particular significance would be a change in the number of women of child bearing age or a shift in population from rural and northern Manitoba to Winnipeg.

2. Although the current Winnipeg capacity appears adequate at the present time and would appear adequate for 1995/96, the obstetrical facilities at HSC and St. Boniface are overcrowded whereas the three other hospitals are operating below capacity.

3. If HSC and St. Boniface are upgraded to provide for 4,500 deliveries each, it can be expected that actual deliveries in both would be at the 4,500 level. If monitoring indicates Winnipeg deliveries in 1995/96 are in the 11,000 to 13,500 range, this would leave 2,000 to 4,500 deliveries to be planned for.

4. The subject of midwifery was raised with the Task Force, however, this subject is to be dealt with by the Alternative Health Care Services Task Force.

RECOMMENDATIONS

1. The Task Force recommends the immediate redevelopment of obstetrical units at the Health Sciences Centre and St. Boniface each for 4,500 annual deliveries.

2. The Task Force recommends that the two teaching hospitals, HSC and St. Boniface, continue to share all anticipated high risk deliveries.

3. The Task Force recommends no closure of urban hospital obstetrical units at the present time and that a decision on the timing of the redevelopment of the obstetric unit at Misericordia be deferred at least until the delivery-related obstetrical anaesthesia funding arrangement is determined in March 1992.

4. The Task Force recommends the appointment of an Urban Hospital Advisory Committee on Obstetrics to meet at least annually to update information on the actual deliveries, updated forecasts and the then current utililzation of obstetric beds. In addition this committee would recommend the allocation of resources both capital and operating. In the view of the Task Force the committee should report to the Minister of Health through the Manitoba Health Services Commission. The committee should have representation from obstetrical units, and from respective hospital administration. It should be consistent with other programmatic task forces and could be expanded to include stakeholders such as health education, ambulatory care and home care programs. It could address some of the potential future concerns regarding alternative care.

APPENDIX I

TASK FORCE GENERAL TERMS OF REFERENCE AND PROCESS FOR THE OBSTETRICS STUDY

The Steering Committee of the Health Advisory Network established the Task Force on Winnipeg Hospitals Role Definition to study the role of each of the acute care hospitals in Winnipeg and to make recommendations concerning the major services to be provided within each hospital.

In setting the stage for its work, the Steering Committee passed to the Task Force several key observations, as follows:

1. Continued improvement in the range and quality of health care services, within reasonable fiscal limits, requires optimal use of resources.

2. Acute care hospital services place the greatest demand on fiscal resources. Improving services and restraining cost increases must involve the role and function of acute care hospitals.

3. The current degree of role differentiation and coordination of services is not optimal. Greater rationalization might enhance quality and cost effectiveness.

4. Strategic Planning exercises by several hospitals have led to specific proposals to the Manitoba Health Services Commission (MHSC) for program and physical developrent with little inter-institutional cooperation.

5. The MHSC has planning parameters based on population projections, inter-provincial comparisons and utilization trends of acute care beds that require further rationalization and explanation.

6. The process of role definition and implementation may take considerable time to complete. Therefore the Task Force, under general terms of reference, may undertake a series of projects.

The general Terms of Reference of the Winnipeg Hospitals Role Definition Task Force are as follows:

TO RECOMMEND ON:

1. Any desirable modifications to planning parameters of the MHSC;

2. The roles of each acute care hospital;

3. The supply and distribution of acute care beds to be achieved by 1996;

4. Desirable developments in ambulatory care facilities;

5. Implications for development plans advanced by the hospitals;

6. Mechanisms for fostering and ensuring coordination and cooperation among hospitals and between hospitals and other health care agencies in program and facilities development and the acquisition and utilization of major equipment installations.

Within these general terms of reference, the first priority assignment given to the Task Force was to review and recommend on the future supply and distribution of obstetrics beds and services for Winnipeg hospitals. Additional direction accepted by the Task Force was that there should be full involvement and collaboration in this review with the hospitals with obstetrical services and with other groups and agencies with an interest in this vital service.

The Task Force met twice in August 1989 to review its terms of reference, to be briefed on Winnipeg's obstetrical services and their profile of financial and statistical information, and to decide on a further process for the review. Five meetings were held in October and these included individual meetings with each of the Winnipeg hospitals with obstetrical services followed by a visit to each and further on-site discussion. In November the Task Force met twice and heard presentations by the Faculty of Medicine, the Manitoba Nurses Union, the Manitoba Association of Registered Nurses and the College of Physicians and Surgeons of Manitoba. Also in November the Task Force heard a presentation on potential for further length of stay reductions by early obstetrical discharge from the Department of Health's Research and Planning Directorate, a presentation by the Manitoba Bureau of Statistics on the potential reductions to Manitoba birthrates, and reviewed obstetrics related recommendations of the (Manitoba) Health Services Review (1985). In December the Task Force met to further review and refine information received and for preliminary discussion of conclusions and possible recommendations. It was agreed the Chairman and Vice-Chairman would meet "informally" with the five hospitals to present the information of the Task Force and invite reaction. These meetings took place on three days in early January 1990.

The Task Force reached its interim conclusions at a meeting in late January. A joint meeting of the Task Force with the five Winnipeg hospitals with obstetrical services was held in mid-March to share these conclusions and seek support for a further process of implementation. Administrators and Heads of Obstetrics from the five Winnipeg hospitals were asked to form an Ad Hoc Committee on Urban Obstetric Hospital Resources to consider the information of this Task Force and recommend a plan for the future. The Ad Hoc Committee reported back to the Task Force in a letter dated August 8, 1990, indicating that they had reached agreement on three points. These are, in the words of the Ad Hoc Committee, as follows:

> "1. That given the projections provided by your main committee of the probable number of deliveries in urban Winnipeg in 1995 there would appear to be a possibility of an excess of hospital resources for urban obstetrics at the time. The Committee agreed that at the present time there appears to be no over abundance of hospital resources. In addition the Committee was of the opinion that current utilization of obstetric beds appears reasonable.

2. The Committee recommends that the development of fetal risk assessment as part of overall pregnancy triage be stepped up within the urban area. The Committee feels that designation of high risk/low risk status based on maternal historical factors alone is no longer appropriate, nor sufficiently accurate to aid in designated functions of primary and tertiary care hospitals.

3. The Committee was unable to provide information to the Task Force regarding how urban obstetric resources should be altered, if at all, in the future. The Committee had some deep concerns about the reliability of estimates of urban obstetric load of 1995. The Committee agrees that if a specific mandate is directed towards them from either the main task force or from government that they would meet again and work ernestly and diligently to develop a plan by which urban obstetric resources could be rationalized according to estimate of need."

Subsequent meetings of the Task Force commenced in October, 1990 to review and finalize this report.

APPENDIX II

MANITOBA OVERVIEW

THE RURAL TO URBAN SHIFT FOR OBSTETRICAL SERVICES

The following table presents an overview of obstetrical service workload trends of Manitoba hospitals for the period 1982/83 through 1989/90. During this period:

- The overall number of deliveries in Manitoba hospitals increased 8.8%;
- deliveries in rural hospitals (excluding the Brandon General Hospital) decreased 8.9%;
- deliveries at the Brandon General Hospital increased 23.8%;
- deliveries in Winnipeg hospitals increased 15.6%.

NUMBER OF DELIVERIES IN MANITOBA HOSPITALS

	Total Manitoba	Rural Manitoba	Brandon	Winnipeg
83/83	16,435	4,845	985	10,600
83/84	17,140	4,920	1,090	11,100
84/85	17,130	4,865	1,150	11,090
85/86	17,540	4,805	1,140	11,580
86/87	17,420	4,550	1,180	11,680
87/88	17,210	4,320	1,260	11,620
88/89	17,630	4,360	1,230	12,040
89/90	17,885	4,415	1,220	12,250
% Change in Period	+8.8%	-8.9%	+23.8%	+15.6%

Deliveries include both liveborns and stillborns, also includes Non-Manitobans delivered in Manitoba hospitals.

The number of non-Manitobans delivered does not change appreciably from year to year hence is not considered a major factor in forecasting future deliveries. Deliveries by non-Manitobans were as follows for the years indicated:

	Deliveries
1983/84	763
1984/85	723
1985/86	719
1986/87	791
1987/88	761
1988/89	795
1989/90	787

(Source: Manitoba Health Services Commission)

Changes to fertility rates and changes to the number of women of child-bearing age within Manitoba's rural regions have contributed to the overall decrease in deliveries in rural hospitals but another primary cause is the rural to urban shift where increasing numbers of rural women sought or were referred to urban obstetrical centres. This shift has levelled off in recent years but likely will not reverse (higher risk rural women will continue to deliver in Winnipeg and current numbers may well increase as high risk case finding improves or becomes more widespread). It is also likely that the increase in deliveries at Brandon will level off. Choosing this as the most likely scenario that would place most pressure on Winnipeg obstetrical services, two conclusions follow:

1. When measured against the total current and anticipated capacity of Winnipeg hospital obstetrical services the rural to urban shift will add an almost negligible number of low risk deliveries to Winnipeg hospitals each year into the foreseeable future.

2. The slow but steady and continuing expected growth of higher risk rural women referred primarily to deliver at the obstetrical services of the Health Sciences Centre and the St. Boniface General Hospital (combined with increasing numbers of high risk newborns transferred to these two hospitals after delivery in rural Manitoba, Brandon or other Winnipeg hospitals as described below) will continue to stretch neonatal intensive care, intermediate care, and labour and delivery resources that have become increasingly tight in recent years at both these two hospitals.

The Manitoba Neonatal Transport Program commenced in July, 1981. A transport team including a physician, nurse and respiratory therapist provides care for sick neonates during transport to the Health Sciences Centre and St. Boniface General Hospital and may be involved in return transports as well. Prior to May 1986 transports were limited to an 80 mile radius of Winnipeg. Now the transport team attends all communities accessible to the Manitoba Air Ambulance (LIFEFLIGHT), including Northwestern Ontario, together with communities served by ground ambulance.

Year	Neonates Transported From			Neonates Transported To		
	Outside Winnipeg	Winnipeg Airport Pick-up	Winnipeg Hospitals	HSC	St. Boniface	Outside Manitoba
(July 1 - June 30 Reporting Year)						
81/82	19	6	47	53	19	-
82/83	25	42	77	100	44	-
83/84	25	48	92	101	64	-
84/85	24	41	94	105	54	-
85/86	31	56	112	141	58	-
86/87	80	25	89	135	53	6
87/88	93	4	78	103	66	6
(April 1 to March 31 Reporting Year)						
88/89	112	6	83	124	63	14
89/90	109	15	104	158	55	15

(Source: Annual Reports of the Manitoba Neonatal Transport Program)

APPENDIX III

WINNIPEG OVERVIEW

HIGH RISK SERVICES AT WINNIPEG HOSPITALS

Schedules I (a) through I(f) (attached) set out risk levels on delivery according to the scoring system[4] of the Perinatal and Maternal Welfare Committee of the College of Physicians and Surgeons of Manitoba. Schedule I(a) reports risk scoring collectively for all Winnipeg hospitals for seven years and Schedules I (b) through I(f) present this information for the five hospitals individually. During these seven years:

- For total Winnipeg deliveries the proportion of high risk deliveries remains about the same (35% to 39%) from year to year;
- The two teaching hospitals, as should be expected, provide a higher proportion of higher risk deliveries than do the three community hospitals. Nevertheless the three community hospitals provide a significant proportion of Winnipeg's higher risk deliveries;
- There are appreciable differences in the proportion of higher risk deliveries between the three community hospitals.

The significance of this information is that public health and prevention measures that have targetted the high risk population have not had an appreciable impact and may have been offset by increased high risk case finding. It appears not much has happened over the seven years to reduce the numbers of high risk deliveries in Winnipeg. This begs the question: can there be and will there be measures of prevention implemented or will even better and more widespread high risk case finding and referral require further investment in costly high risk obstetrical, neonatal and follow-up programs of the two teaching hospitals?

Equally significant is the observation that there will always be a proportion of deliveries that become high risk even at hospitals that attempt to limit themselves to a low risk service. The Schedules I(d),(e) and (f) show marked differences between the three community hospitals. Victoria prides itself as a lower risk obstetrical centre whereas Grace prides itself as a centre capable of accepting deliveries of slightly higher risk.

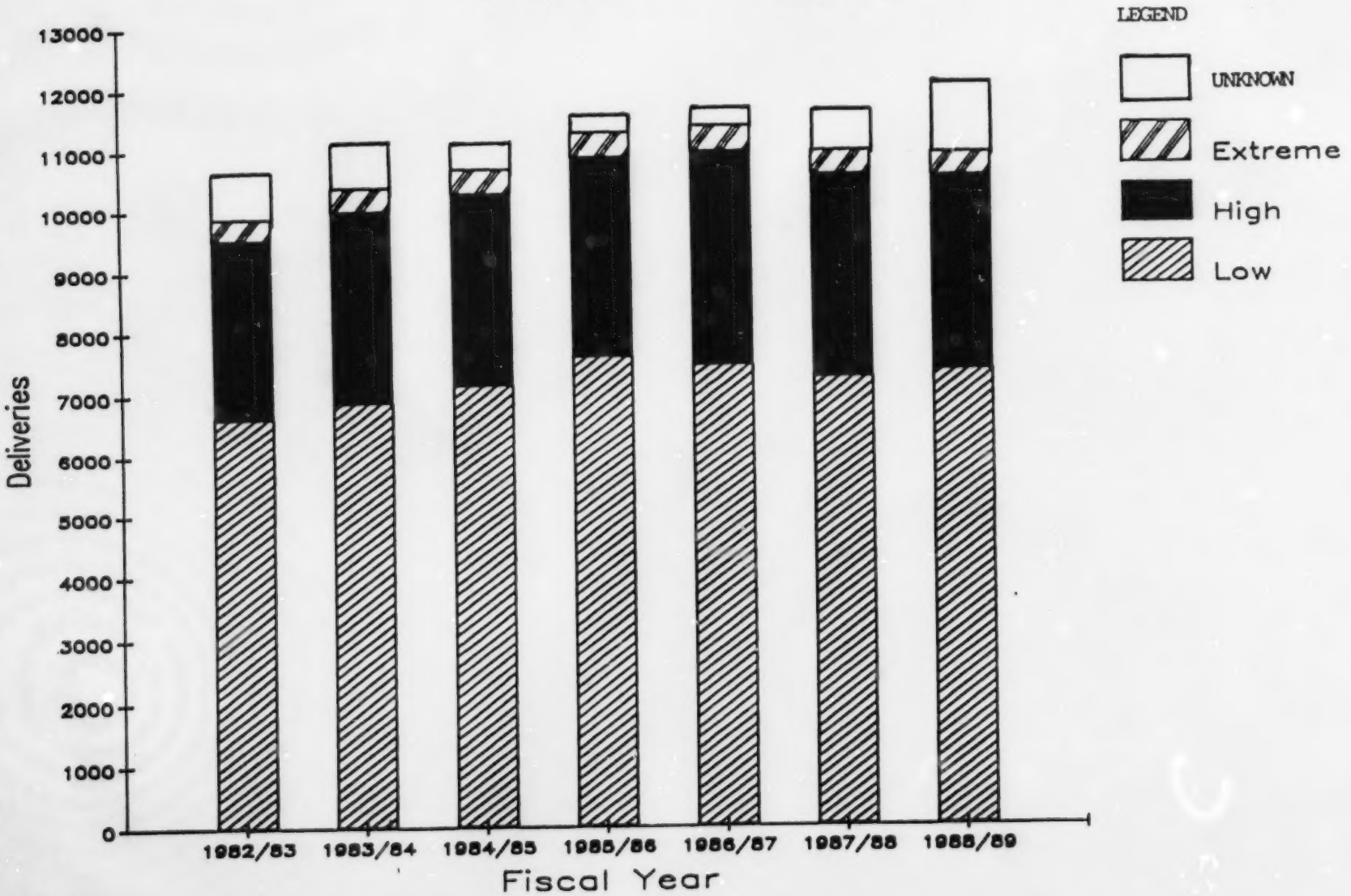
Grace was the first of the Winnipeg community hospital obstetrical services to be funded for a 24-hour obstetrical anaesthesia standby service. This obstetrical anaesthesia service has now become the standard at all three Winnipeg community hospital obstetrical services at a medical remuneration cost well in excess of $1 million yearly. This is a most valuable service nevertheless it consumes the equivalent of 10 to 15 full-time anaesthetists at a time when the supply of anaesthetists is short both nationally and locally.

(4) Scores are broken down into risk levels as follows:

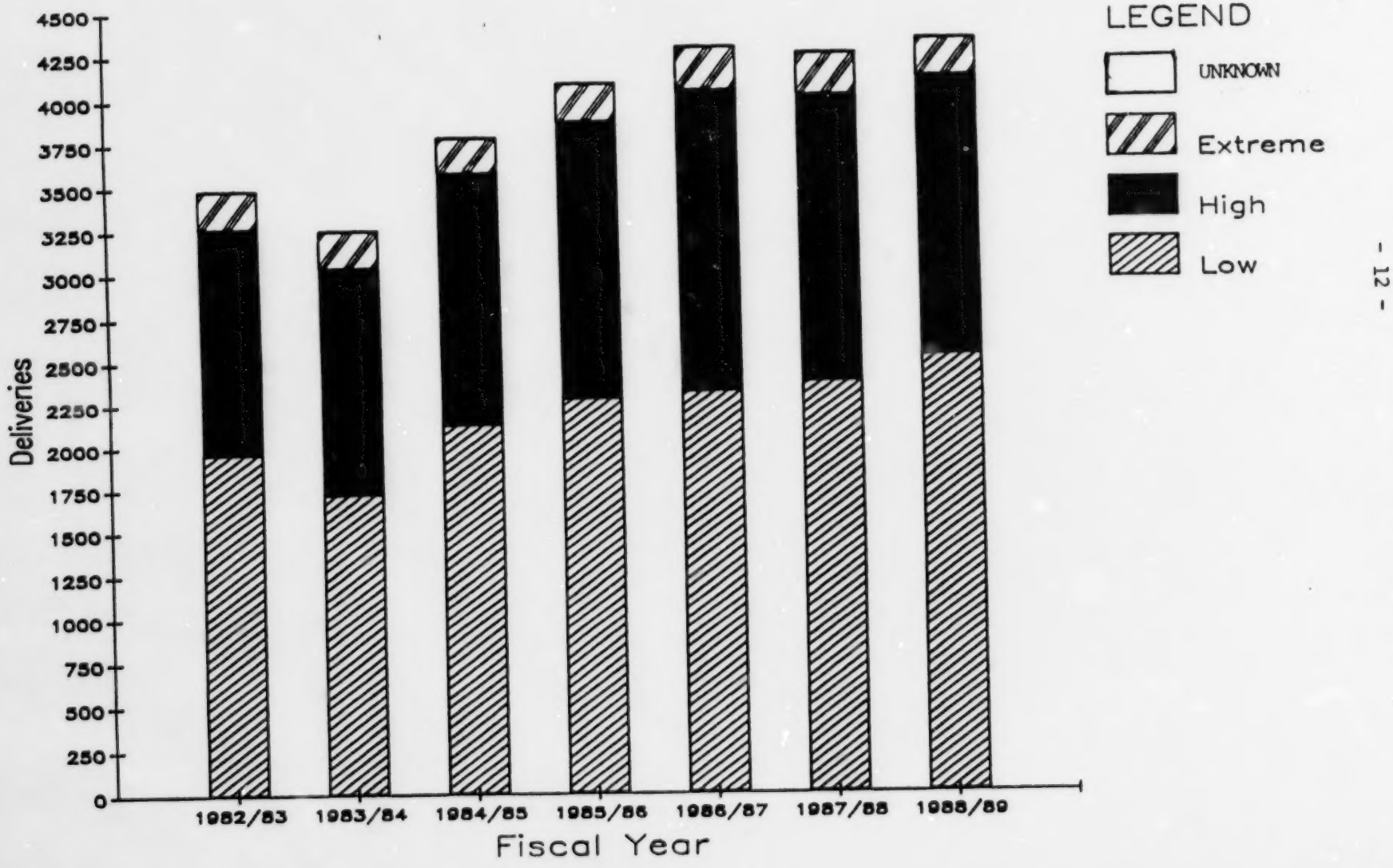
	Score
Low Risk	00 - 02
High Risk	03 - 06
Extreme Risk	07 - 98
Unknown Risk	99

SCHEDULE I (a)

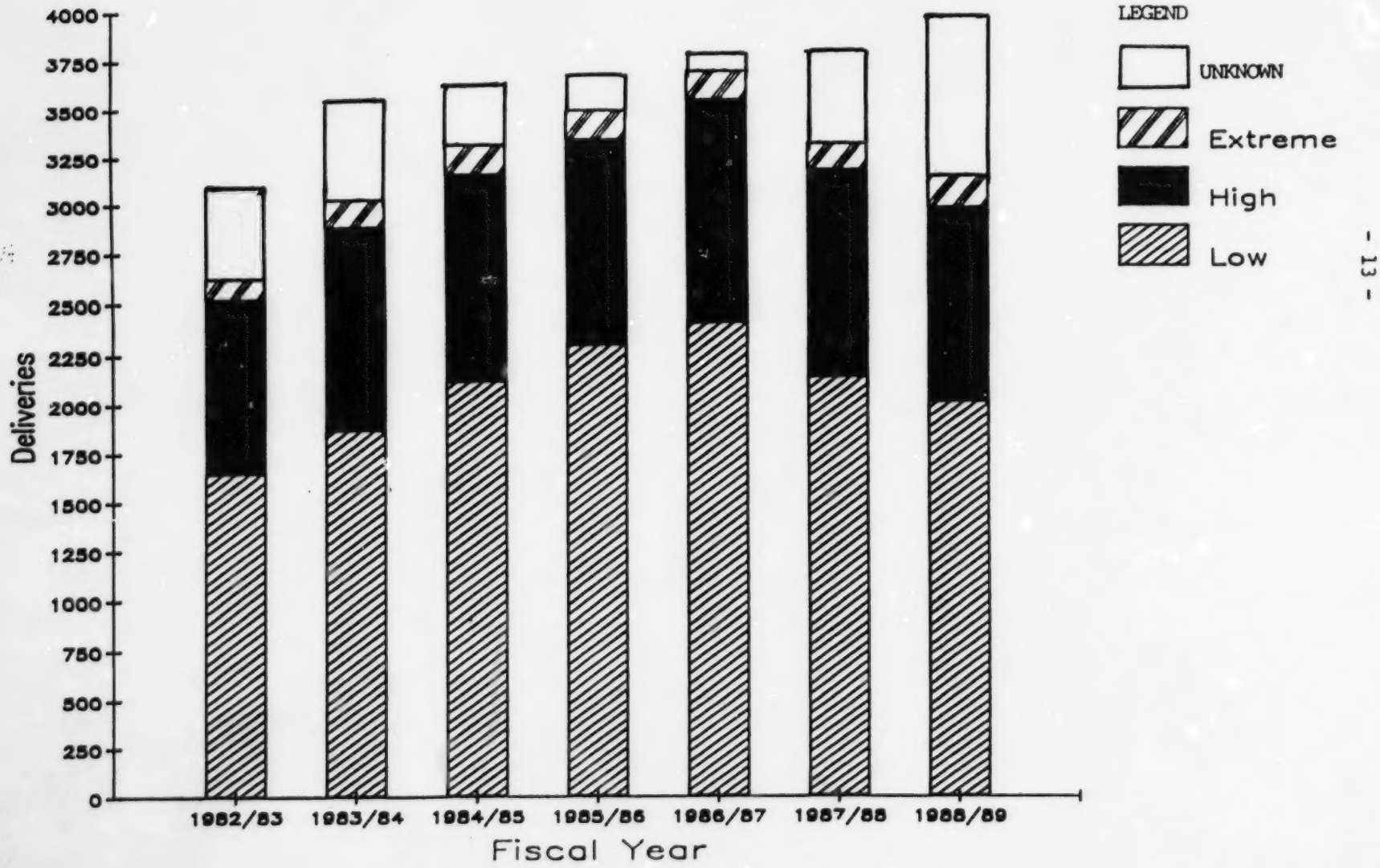
MANITOBA HEALTH SERVICES COMMISSION
DELIVERIES BY RISK SCORE FOR ALL WPG. HOSPITALS
1982/83 TO 1988/89



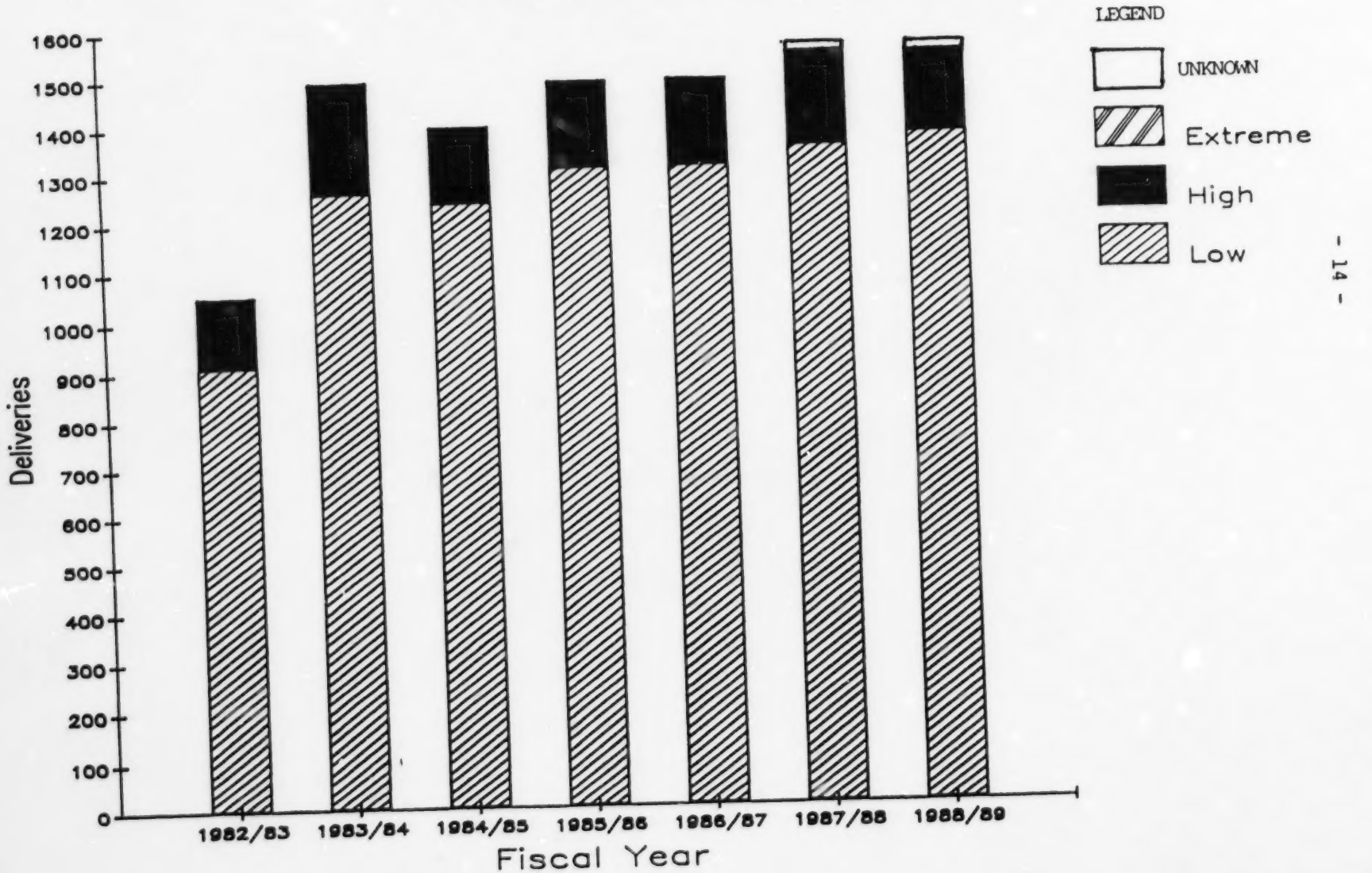
MANITOBA HEALTH SERVICES COMMISSION
DELIVERIES BY RISK SCORE FOR ST. BONIFACE HOSPITAL
1982/83 TO 1988/89



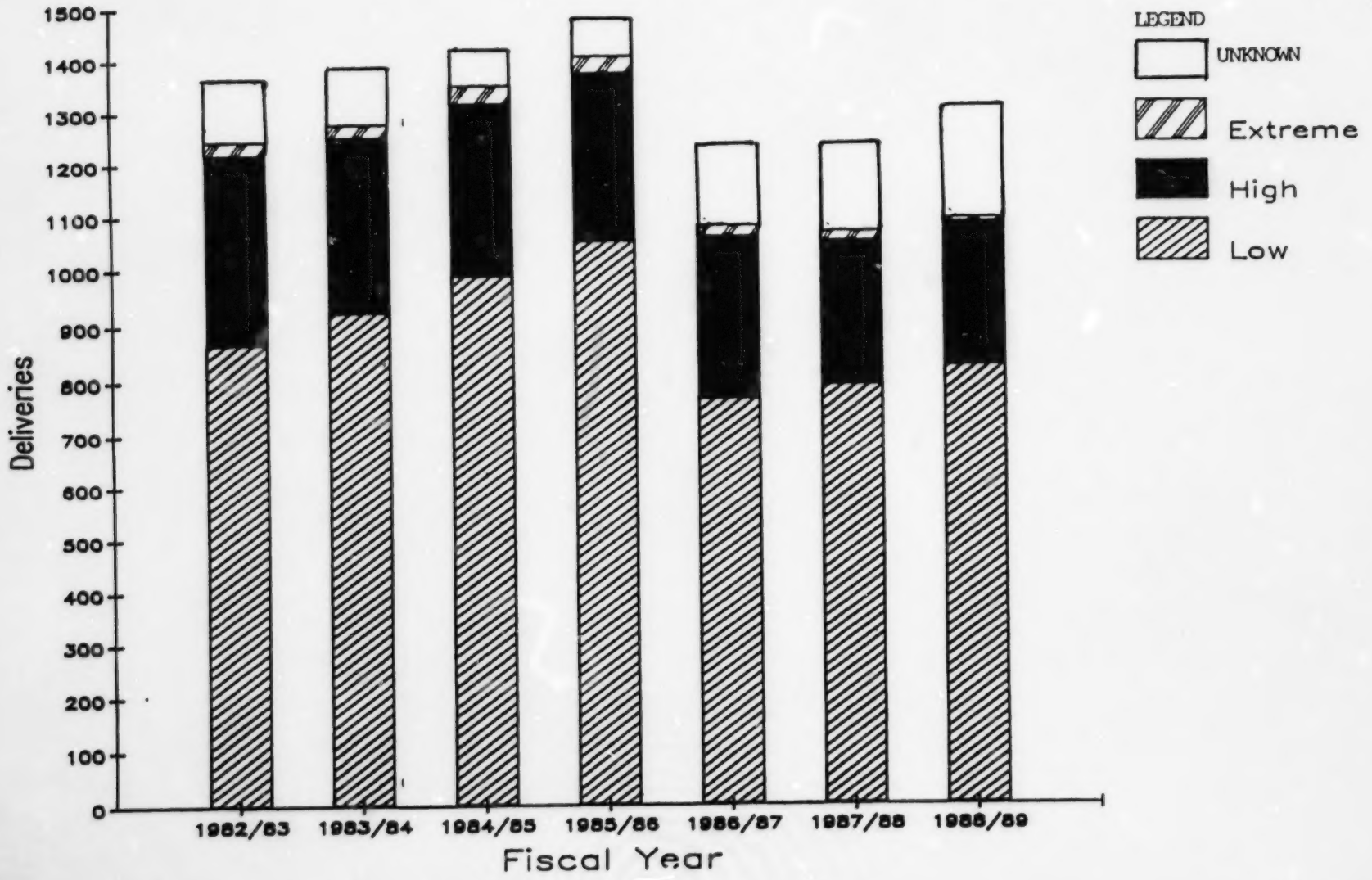
MANITOBA HEALTH SERVICES COMMISSION
DELIVERIES BY RISK SCORE FOR HEALTH SCIENCES CENTRE
1982/83 TO 1988/89



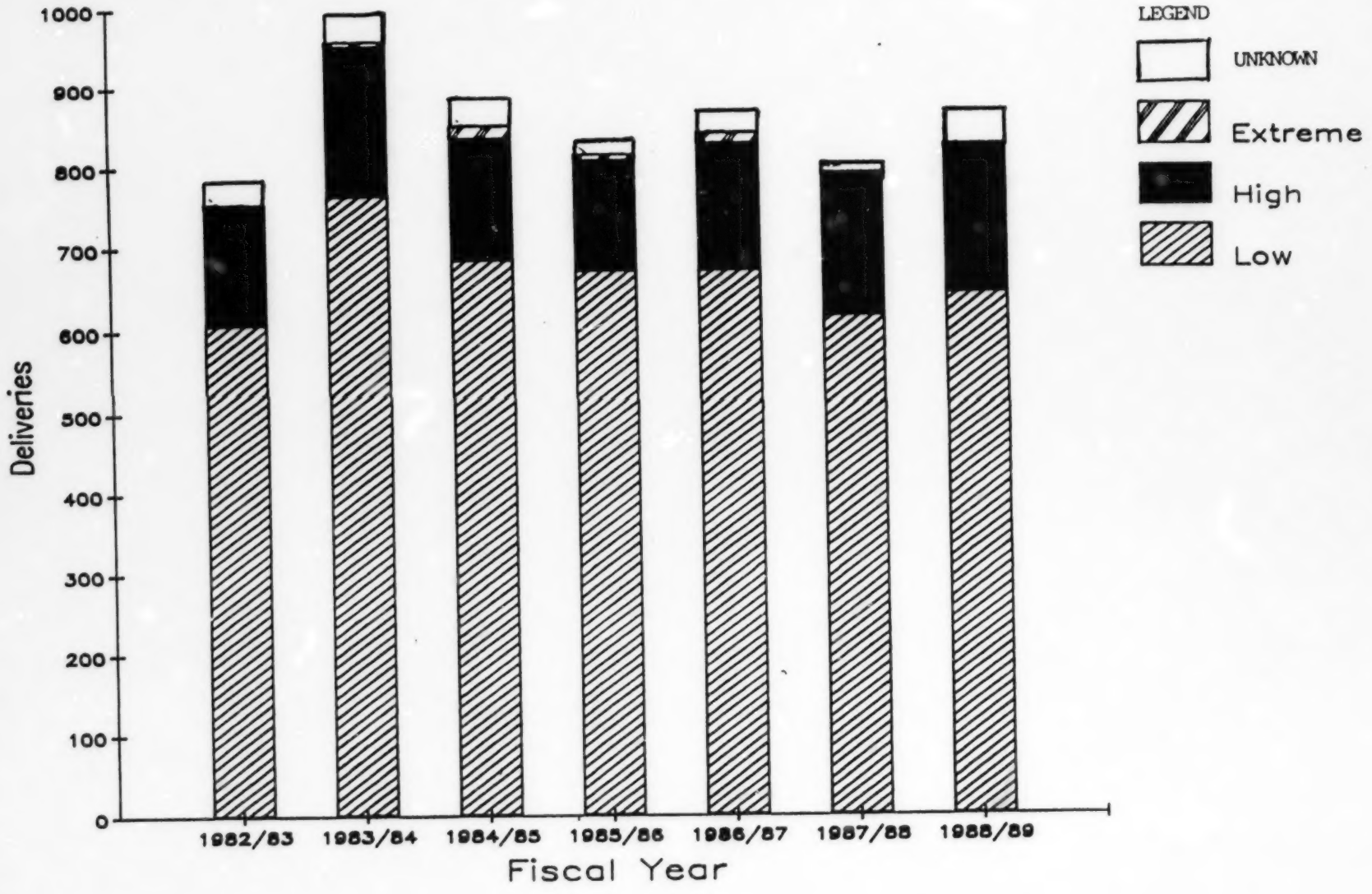
MANITOBA HEALTH SERVICES COMMISSION
DELIVERIES BY RISK SCORE FOR VICTORIA HOSPITAL
1982/83 TO 1988/89



MANITOBA HEALTH SERVICES COMMISSION
DELIVERIES BY RISK SCORE FOR GRACE HOSPITAL
1982/83 TO 1988/89



MANITOBA HEALTH SERVICES COMMISSION
DELIVERIES BY RISK SCORE FOR MISERICORDIA HOSPITAL
1982/83 TO 1988/89



APPENDIX IV

WINNIPEG OVERVIEW
PROFILES OF PHYSICIAN PRACTICES

Schedules II (a) and II (b) (attached) set out, for the years 1982/83 and 1988/89, the number of deliveries by obstetricians and non-obstetricians in the five Winnipeg hospitals.

Profile of Obstetricians

- At the two teaching hospitals most (over 80% at St. Boniface and almost 90% at HSC) deliveries are performed by obstetricians. Two-thirds of these obstetricians perform over 100 deliveries each year, a dozen or so obstetricians do very few deliveries and a handful do between 25 and 100 deliveries yearly. In 1988/89 there were 32 obstetricians with larger practices (in excess of 100 deliveries) at these two hospitals.

- At the Victoria and Grace Hospitals approximately one-third of deliveries are performed by obstetricians (40% at Victoria and 33% at Grace). In 1988/89 there were two obstetricians at Victoria and two obstetricians at Grace who performed in excess of 100 deliveries.

- At the Misericordia Hospital a slightly larger proportion of deliveries seem to be performed by obstetricians (58% in 1988/89) than at Victoria and Grace. In 1988/89 there were two obstetricians at Misericordia who performed in excess of 100 deliveries.

Profile of Non-Obstetricians

- At the two teaching hospitals only a small proportion of total deliveries are performed by non-obstetricians. At HSC a handful of non-obstetricians performed between 25 and 50 deliveries (one performed 165 deliveries) in 1988/89. At St. Boniface in 1988/89, reflecting the influence of the family practice group, about 20 non-obstetricians performed between 11 and 25 deliveries and 10 non-obstetricians performed between 26 and 50 deliveries (none performed more than 50).

- At the three community hospitals, the majority by far of deliveries are performed by non-obstetricians. In 1988/89, 10 non-obstetricians performed between 50 and 100 deliveries each and 14 performed between 26 and 50 deliveries each.

- Note the large numbers of non-obstetricians who perform fewer than 25 deliveries each year - at all five hospitals.

Percent Deliveries by Obstetricians and Non-Obstetricians

	1982/83		1988/89	
	Obstetricans	Non Obstetricians	Obstetricians	Non Obstetricians
St. Boniface	81.7%	18.3%	81.5%	18.4%
H.S.C.	94.3%	5.7%	88.5%	11.5%
Victoria	32.8%	67.2%	41.8%	58.2%
Grace	31.9%	68.1%	33.7%	66.3%
Misericordia	44.5%	55.5%	57.6%	42.4%

The information of Schedules II (a) and II (b) is significant in that it shows the effect one busy obstetrician moving from one hospital to another can have on the individual hospital workloads. There is less of a workload change, obviously, when a non-obstetrician relocates.

Should there be a further consolidation of obstetrics within the community hospitals, these Schedules also give some idea of the extent of disruption there would be among obstetricians and non-obstetricians. Non-obstetricians would be much less likely to relocate and would instead be forced to give up this part of their practices.

Schedule II (a)

WINNIPEG DELIVERIES BY OBSTETRICIANS - 1982/83 AND 1988/89

NUMBER OF OBSTETRICIANS

# of Deliveries	St. Boniface		HSC		Victoria		Grace		Misericordia		Total[1]	
	82/83	88/89	82/83	88/89	82/83	88/89	82/83	88/89	82/83	88/89	82/83	88/89
1 - 5	7	4	4	9	3	5	2	1	4	5	0	17
6 - 25	1	1	4	-	3	1	3	1	2	2	4	1
26 - 50	3	-	2	-	-	2	-	1	1	2	7	-
51 - 75	-	-	2	-	1	2	-	-	-	1	2	1
76 - 100	-	1	2	1	-	-	1	-	-	-	4	1
101 - 125	1	3	-	1	1	-	-	-	-	1	-	4
126 - 150	2	-	2	2	1	-	1	-	2	-	4	2
151 - 175	2	2	-	2	-	-	-	1	-	-	4	3
176 - 200	1	2	5	1	-	1	1	-	-	-	3	3
201 - 225	3	2	1	3	-	1	-	1	-	-	4	5
226 - 250	1	-	1	3	-	-	-	-	-	1	3	4
251 - 275	2	1	1	3	-	-	-	-	-	-	4	4
276 - 300	-	-	1	-	-	-	-	-	-	-	1	1
301 - 400	1	1	1	1	-	-	-	-	-	-	3	2
401 - 500	-	3	-	-	-	-	-	-	-	-	-	3
510	-	-	-	-	-	-	-	-	-	-	-	1
531	-	-	-	-	-	-	-	-	-	-	1	-
698	-	-	-	-	-	-	-	-	-	-	-	1
Total	24	20	26	26	9	12	8	5	9	12	44	53
Deliveries by Obstetricians	2,845	3,538	2,954	3,350	346	651	437	443	349	502	7,082[2]	8,664
Deliveries by Non-Obstetricians	638	800	178	458	708	905	931	870	435	369	3,545[3]	3,402
Total Deliveries	3,483	4,338	3,132	3,988	1,054	1,556	1,368	1,313	784	871	10,627	12,066
% by Obstetrician	81.7%	81.5%	94.3%	88.5%	32.8%	41.8%	31.9%	33.7%	44.5%	57.6%	66.6%	71.8%

(1) The obstetricians may deliver in more than one hospital(hence this total column is not the sum of the numbers at each hospital). There are 18 obstetricians who peformed 50 or less deliveries in all Winnipeg hospitals in 1988/89 (43 deliveries total for the 18). In 1982/83 there were 11 obstetricians who performed 50 or less deliveries.

The "average" obstetrician performed 246 deliveries in 1988/89 (eliminate the 18 who performed a total of 43 deliveries: hence 35 obstetricians performed 8,621 deliveries). Similarly, in 1982/83 the "average" obstetrician performed 204 deliveries.

(2) Includes 151 deliveries by 12 obstetricians at Concordia and Seven Oaks Hospitals.

(3) Includes 655 deliveries by 66 non-obstetricians at Concordia and Seven Oaks Hospitals.

Schedule II (b)

WINNIPEG DELIVERIES BY NON-OBSTETRICIANS - 1982/83 AND 1988/89

NUMBER OF NON-OBSTETRICIANS

# of Deliveries	St. Boniface		MSC		Victoria		Grace		Misericordia		Total[1]	
	82/83	88/89	82/83	88/89	82/83	88/89	82/83	88/89	82/83	88/89	82/83	88/89
1 - 5	26	34	20	22	21	40	7	13	20	25	61	79
6 - 10	13	7	7	2	5	9	4	6	7	8	35	21
11 - 15	8	10	-	2	3	4	8	8	8	3	38	26
16 - 20	2	2	-	1	6	2	11	8	2	6	24	21
21 - 25	2	7	1	-	5	3	5	3	3	2	18	13
26 - 30	-	4	-	-	3	1	1	4	3	-	9	11
31 - 35	3	3	-	3	3	4	2	3	-	-	8	13
36 - 40	2	1	-	1	1	-	1	1	1	-	6	6
41 - 45	-	1	-	-	-	-	4	1	-	-	7	1
46 - 50	1	1	-	-	-	-	-	-	-	-	1	1
51 - 55	-	-	-	1	-	-	-	1	-	-	1	3
56 - 60	-	-	-	-	-	2	3	-	-	-	4	1
61 - 65	1	-	1	-	1	-	-	-	-	1	1	2
66 - 70	-	-	-	-	-	-	-	-	-	-	1	-
71 - 75	-	-	-	-	-	3	-	2	-	-	2	3
76 - 80	-	-	-	-	-	-	-	-	-	-	-	1
81 - 85	-	-	-	-	1	-	-	-	-	-	2	1
98	-	-	-	-	-	1	-	-	-	-	-	1
185	-	-	-	1	-	-	-	-	-	-	-	1
Total	58	70	29	33	49	69	46	50	44	45	218	205
Deliveries by Non-Obstetricians	638	800	178	458	708	905	931	870	435	369	3,545[2]	3,402
Deliveries by Obstetricans	2,845	3,538	2,954	3,530	346	651	437	443	349	502	7,082[3]	8,664
Total Deliveries	3,483	4,338	3,132	3,988	1,054	1,556	1,368	1,313	784	871	10,627	12,066
% by Non-Obstetrician	18.3%	18.4%	5.7%	11.5%	67.2%	58.2%	68.1%	66.3%	55.5%	42.4%	33.3%	28.2%

(1) The non-obstetrician may deliver in more than one hospital (hence this total column is not the sum of the numbers at each hospital). In 1988/89 there were 79 non-obstetricians who performed 5 or less deliveries in all Winnipeg hospitals; 160 performed 25 or less and 192 performed 50 or less. There may be a few non-obstetricians who perform additional deliveries in rural hospitals.

(2) Includes 66 non-obstetricians who performed 655 deliveries at the Concordia and Seven Oaks Hospital.

(3) Includes 151 deliveries by 12 obstetricians at Concordia and Seven Oaks Hospitals.

APPENDIX V

WINNIPEG HOSPITAL OBSTETRICAL SERVICES
ISSUES AND CONCERNS

In September, 1989, the Task Force wrote to the five Winnipeg hospitals with obstetrical services inviting representation from each at separate meetings. In extending these invitations, the Task Force asked each hospital to address the following three questions:

1) What are the issues, concerns and your recommendations with respect to the current volume of obstetrics services your hospital is providing?

2) What is the current maximum physical capacity of your obstetrical spaces? To what service volume level could this be increased with relatively minor space reallocations or renovations?

3) What is your hospital's view of the future delivery of obstetrics services in Winnipeg and your role in this future system? What are the issues you see that should be faced?

The following sections report on the written and verbal presentations of the hospitals supplemented by additional information from the site visits by the Task Force and later clarifications where necessary.

ST. BONIFACE GENERAL HOSPITAL

The St. Boniface General Hospital has been the leading provider, in terms of numbers of deliveries, of obstetrics services in Winnipeg for several years. They say there is no evidence suggesting the trend of increasing numbers of deliveries expected of St. Boniface will change. Much of this is attributed to the hospital's reputation for exemplary maternity and newborn care. "The hospital provides obstetric services to just less than 40% of patients giving birth in...Winnipeg, and we anticipate that this percent will continue to increase."

They say..."that this has been possible is a tribute to the intensive effort of the staff...the (obstetrics) facility is grossly constricted and outdated given the dominant role it provides...". "As rural patients move to urban delivery, as satisfied patients tell their friends where they received good services, and as the city's younger and reproducing population grows in the south and eastern portions of Winnipeg, the same physical facility has met a progressively increasing demand." "Despite these (physical) limitations...stillbirth and neonatal death rates have continued to fall, and perinatal mortality figures are the lowest they have ever been in the hospital's and province's history."

"It is our goal that our services be exemplary and accessible to any of the province's citizens who need them."

The hospital has set the upgrading of the obstetrics facility as one of its highest priorities. This will be achieved in the Eastside construction project timed to follow in sequence with the Westside construction now underway. The hospital hopes to complete the obstetrics development within four to five years.

In response to the Task Force's question of what service volume levels St. Boniface could increase to with relatively minor space reallocations or renovations, the answer given was "none whatsoever". They feel they are "at capacity" with deliveries approaching 4,500 per year which is "...in addition to patients being transferred on arrival or diverted in labour to other institutions, and in addition to an unknown number being urged or requested by their physicians to deliver at one of the other hospitals due to occupancy stress at St. Boniface." The hospital advises it is planning for a projected volume of 5,000 deliveries per year.

The hospital advises that "...obstetrical care should not be centralized for the sake of centralization, without the meticulous assessment of the needs of a given community. However, given that five hospitals in Winnipeg are providing obstetric care for our urban and referred rural population, a needs assessment is inevitable." They suggest a specific concern is the decreasing availability of anaesthesia resources (reference to the three community hospital obstetric services each requiring 24 hour on-site obstetrical anaesthetists). "Concentration of special skills and technologic resources necessary to provide appropriate care....is appropriate in this city...".

The hospital suggests that there should be a comparison with costs of preventative strategies. "An infant born at less than 1,000 grams will cost the province $100,000 by the time it goes home to its parents." The hospital, they say, ..."must develop educational and promotional programs in perinatal health and effective strategies for prevention of low birth weight and prematurity."

The hospital summarized its representation with the statement that "...the evolution of consumer demand in Winnipeg, in Manitoba and the academic role of the St. Boniface General Hospital, define its future role for us with respect to the provision of obstetrical services...we have the skills and the personnel to do the job required, given provision of the appropriate physical facility."

HEALTH SCIENCES CENTRE

The spectrum of care provided by the Women's Hospital and the Children's Hospital ranges from family oriented highly specialized services for critically ill neonates to tertiary care services provided in concert with the St. Boniface General Hospital, to secondary care services to the remote communities of Northern Manitoba and the Northwest Terrritories, and to primary care for Winnipeg residents particulary those of the core area. A national and international role is played by the Fetal Therapy Program (referral unit for allo-immunized fetal anemias and fetal anomalies amenable to "in utero" surgery). Winnipeg's fetal assessment programs are sited at both the Health Sciences Centre and St. Boniface General Hospital but most diagnostic work is done at H.S.C. (Genetic Prenatal Diagnosis Program, Maternal Alpha-fetoprotein Screening, the PUBS Program and the RH Program are all located at Women's).

The submission from the Health Sciences Centre makes the point that the potential for prospective accurate risk evaluation will permit rational distribution of high risk/low risk patients to appropriate facilities. It is becoming very possible to assign perinatal risk with high precision based on fetal data, they say, and this will enhance and ultimately interact with traditional risk assessment derived from maternal data. The impact of this increased precision is that the proportion of true high risk deliveries at the two teaching hospitals will continue to increase with obvious implications for skilled staff, equipment and space. Also, the demand for specialized ambulatory services such as prenatal diagnosis by CVS or amniocentesis is expanding with obvious cost implications (Women's is the single referral source for prenatal diagnosis and pregnancy counselling).

Similar evolutionary pressures are being experienced by the neonatal services of Children's Hospital.

Several issues and concerns were identified by the Health Sciences Centre as follows:

1. The fragmented locations of critical care areas (the Intermediate Care Nursery at Women's and the Neonatal Intensive Care Unit at Children's), the deficient physical structure at Women's, and the lack of space must be resolved. The solution is to include new obstetrics space in the first phase of the major redevelopment of the Health Sciences Centre known as "HA" which would consolidate obstetrics with the services of Children's.

2. Rational planning for support service personnel and program management must be intitiated. For example, if the Health Sciences Centre is to become the most used tertiary centre for premature infants then planning and funding over and above that based on hospital delivery rates alone is essential. The Genetics Program and Fetal Assessment Programs, too, must be addressed and there are other examples where attention to existing problems can yield long term successful programs.

3. The scope of obstetrics services for the entire urban area must be defined. What happens to obstetrics services outside HSC strongly impacts on what happens at HSC. The high risk mix at HSC will continue to increase the strain on resources. Growing patient awareness of the excellence of care of tertiary institutions who can offer both low risk and high risk services

will continue to attract increasing numbers of deliveries. Promotion of low risk centres may not be well accepted by the community at large, nevertheless, routine risk assessment (leading to streaming deliveries to centres in accordance with risk) should be encouraged.

4. The needs for early postpartum discharge programs, for better utilization of antepartum assessment areas, for a pre-labour assessment area and for a high risk maternal stabilization program are clear. It is possible to achieve these goals in a short period of time, they say, by a reallocation of existing services, by provision of some capital and personnel resources at the hospital centres and by mobilization and utilization of existing community nurse and other professional services.

VICTORIA HOSPITAL

In its presentation, the Victoria Hospital said they believe they can become a centre of excellence for low risk obstetrics. They support decentalization of lower risk obstetrics into community hospitals but believe only one or two such centres are needed in Winnipeg.

The Victoria General Hospital obstetrical facility was built in 1971 when this hospital moved to its current Fort Garry site. Originally 38 postpartum beds were provided but only about 20 are used routinely now, the other 18 are rarely used for obstetrics and instead are used for "clean" surgery. Over the past few years there has been a significant reduction to length of stay (to 3.3 days in 1988/89). If length of stay were further reduced to 2.9 days, 2,900 deliveries could be accommodated (4,000 deliveries if 2.75 days stay) if all 38 post partum beds were used, according to the hospital. A significantly larger service could be accommodated at Victoria with very little construction they say.

The hospital said centralization of all obstetrics at the teaching hospitals is not supported because decentralization better serves families in the suburbs and family practioners who deliver low risk cases.

They are working to improve neonatal care (family practitioners and anaesthetists are training at HSC). Provision of an intermediate risk program would not involve much physical change (construction) but would require an investment in medical and nursing staff.

The hospital indicated Fort Garry and St. Vital are expected to continue current growth rates. Also the hospital has come to serve rural areas to the south and east of Winnipeg increasingly in the past several years.

GRACE HOSPITAL

The Salvation Army came to Winnipeg in 1889 and became involved in the care of unwed mothers, an activity that continues today in the Lindenview Residence adjacent to the Salvation Army Grace Hospital. The original Grace Hospital had its beginning in serving obstetrical patients.

In recent years the hospital has worked particularly hard to enrich the obstetrical service such as by providing birthing rooms. An out-patient obstetrical clinic was established in February, 1989, and by the end of the year was seeing approximately 130 patients monthly. The clinic's purpose is to "..recruit local residents desirous of specialist care to enable them to be seen adjacent to the hospital without having to travel to downtown offices."

The Board has attempted to recruit graduating obstetricians with little success. They say they are greatly concerned with the lack of obstetricians and calculate that..."the area served by the Grace Hospital should have 5 Obstetrician and Gynecology specialists".

In 1986/87 an obstetrician left Grace for an appointment at the Health Sciences Centre and thereby transferred approximately 250 deliveries yearly from Grace to the Health Sciences Centre. The move of one obstetrician from a community hospital can transfer a workload of 15% to 20% of the hospital's total deliveries.

The Grace Hospital has promoted an increase in deliveries in recent years by "...encouraging participation of new members of the Department of Family Practice in taking up obstetrical care." They attribute a modest rise in deliveries in 1988 to these efforts. They recruited 2 obstetricians in 1988 and this has had a more significant affect on increasing deliveries.

The hospital reports their obstetrical capacity is such that they "...could build to 2,000 deliveries annually. Renovations, other than minor changes to the facility, would not be required for this service volume increase, but the staffing of nurses and doctors would have to increase." They say that they look forward to the day when with 2,000 deliveries annually, consideration could be given to the development of an Intensive Care Nursery with formal undergraduate and postgraduate (medical) education. They say their greatest current need continues to be for additional certified obstetricians and gynecologists and attempts to obtain help from the University of Manitoba have not been fruitful. They recommend that "...the current excessive load at the tertiary hospitals could be addressed by diversion of primary and secondary obstetrics to community hospitals" and that "...undergraduate and postgraduate (medical) students in community hospitals as a rotation would provide exposure and excellent hands-on experience in clinical obstetrics"

MISERICORDIA HOSPITAL

The Sisters of Misericorde arrived in Winnipeg more than ninety years ago to minister to pregnant women. They created a home for single, pregnant women and a maternity hospital. That hospital grew and became the Misericordia General Hospital in 1917. The Sisters have made it very clear that they want obstetrics to remain a vital part of the hospital's service and this commitment is reflected by the Board, administration and staff.

They say Misericordia "...caters to the low risk obstetrics community, as well as providing assessment, stabilization and transfer of high risk patients." Obstetrical consultation and referral services are provided and comprehensive prenatal education seminars are offered at no charge. They provide "...family centered maternity care with a comprehensive post partum education program....designed to meet the total needs of the client and her family, allowing flexibility and respecting cultural and religious needs". They say "...our human resources and present physical lay-out could easily handle 1,400 deliveries annually."

In recent years, the hospital identified two concerns that promoted a serious look at the obstetrics service. The first concern arose over suggestions that Winnipeg obstetrics should be centralized in the two teaching hospitals. The second concern was evidence that a trend was developing of reducing numbers of deliveries at Misericordia. Accordingly, the Board established a Task Force which made three key recommendations (seven other lesser recommendations) that received the following quick action:

1) On-site 24 hour obstetrical anaesthesia services commenced in 1988/89.

2) St.Boniface Family Practice physicians were contacted and encouraged to perform more of their lower risk deliveries at Misericordia. Also, a public awareness campaign commenced.

3) A second birthing room was created.

Misericordia say they oppose centralization of obstetrics in the two teaching hospitals for fundamental reasons fearing this would not mean improved obstetrical care and "...goes against the wishes of the majority of women who are trying to return the birthing process to a more natural, less technical event."

Misericordia supports having high risk cases at the teaching hospitals and say they screen their cases accordingly. In order to enhance cooperation with the St. Boniface Hospital, a Joint Committee was established in January, 1989. The hospital believes that "...better levels of cooperation and understanding between the units in both hospitals could mean better distribution of the caseload. This would serve the patients and more cost effectively use the resources which are already in place."

As objectives for 1990, the Misericordia Board enunciated three that relate specifically to obstetrics as follows:

1) To continue discussions with St. Boniface Hospital regarding the transfer of low-risk obstetrical patients;

2) To foster recruitment of active obstetricians to the obstetrical service; and

3) To actively support the recommendations of the (Misericordia) obstetrical Task Force to achieve 1,200 deliveries per year.(1)

(1) In its letter dated April 14, 1989, approving funding for the obstetrical anaesthesia sessional arrangement, the Manitoba Health Services Commission asked Misericordia to concur that the sessional arrangement will be terminated effective March 31, 1992 if deliveries do not reach 1,200 yearly by that date. The hospital responded in a letter dated April 26, 1989 indicating they "...agree with you that achieving a level of 1,200 deliveries per year by March 1992 is a reasonable one."

APPENDIX VI

OTHER INTERESTED AGENCIES ISSUES AND CONCERNS

The Task Force also received representations from the Manitoba Association of Registered Nurses, the Manitoba College of Physicians and Surgeons, Manitoba Organization of Nurses' Associations (now the Manitoba Nurses Union), the University of Manitoba Faculty of Medicine and the Research and Planning Directorate of the Manitoba Department of Health. The following sections review these representations.

MANITOBA ASSOCIATION OF REGISTERED NURSES (MARN)

The MARN reminded the Task Force of the five basic principles of the Canadian health care system, namely: universal coverage, comprehensiveness, accessibility, portability and public administration. They suggested the 55 recommendations of the Report of the Obstetrics Review Committee dated January 15, 1985, "...provide an excellent overview of the changes that were seen to be appropriate for the consumer of obstetrical services as the services existed in 1985..(and many)reflect accurately the situation as it exists today." Many have been implemented, some with appropriate modifications, nevertheless many have not been implemented. This led to the MARN recommendation that the Task Force should review the recommendations not yet implemented, in particular the two recommendations that address the expanded role of the nurse in reproductive health care.

The MARN also took this opportunity to remind the Task Force of their position on minimum education requirements for entry into the practice of nursing.

On the question of midwifery, the MARN quoted their Board's position statement made on August 30, 1989 which is as follows:

> "The Manitoba Association of Registered Nurses (MARN) recognizes that the majority of births are normal and without complications. Therefore, the MARN supports the development of Registered Nurse midwifery as a nursing specialty which requires specific education and expertise. The MARN believes the health care delivery system should include the role of the Registered Nurse midwife as a member of the obstetrical care team in the provision of individualized comprehensive prenatal, birth and postnatal family care. (MARN, 1986) This role is consistent with the changes in the scope of practice of nursing. (Canada Health Act; Canadian Nurses Association, 1984)"
>
> (This statement continues with a definition of "midwife" and "sphere of practice")

They clarified that MARN supports Registered Nurse midwives for low risk (normal) obstetrics. Midwives would be part of a team and subordinate to the family practitioner. The Nurses Protective Society could cover nurse midwives (insurance liability) as part of the acceptable scope of nurse practice.

MANITOBA COLLEGE OF PHYSICIANS AND SURGEONS

The College presentation noted the steady growth in deliveries at the two teaching hospitals and indicated this has not adversely affected standards. They suggested the Winnipeg hospitals do not appear to have clear role definition in the sense that low obstetrical volumes at some complicate their ability to function (whereas, at others, high volumes complicate function). They said they were concerned with decreasing viability of many rural hospitals and the increasing shift from rur l to urban for normal obstetrics.

The College presentation identified the following as concerns with respect to support services for obstetrics in Winnipeg community hospitals:

1) Inconsistent availability of specialist medical services, in particular, of obstetricians and pediatricians on-site; and

2) Absence of universal anaesthesia standards (they identified the College would be addressing this deficiency shortly).

They reminded the Task Force that consumerism is of increasing influence with trends of increasing demands for sympathetic and non-technological physical surroundings, for transport and accommodation of high risk rural patients, of questioning the role of teaching hospitals in low risk obstetrics and of patients not wanting to be part of teaching programs.

THE MANITOBA NURSES' UNION

THE MANITOBA ORGANIZATION OF NURSES' ASSOCIATIONS (M.O.N.A.)

The M.O.N.A. (now known as the Manitoba Nurses' Union) presentation indicated to the Task Force that their position, reaffirmed in 1988, on further centralization of obstetrical services in Winnipeg is as follows:

> "M.O.N.A. believes that community hospital obstetical units must remain accessible to expectant families. M.O.N.A. is opposed to further centralization of obstetrical services which would result in closure of obstetrical units at Misericordia, Victoria and Grace Hospitals"

They also presented their position on midwives as follows:

> "M.O.N.A. endorses that midwives must be registered nurses and must be licensed as nurse midwives. Midwifery training must be regarded as a continuation of registered nurse training."

The M.O.N.A. presentation listed several concerns as follows:

1) High risk units are not the place for "normal low risk" mothers to receive optimal care.

2) Because of the high admission rate to both Winnipeg high risk units and the resultant overcrowding, nurses feel that the "assembly line" experience detracts from the birthing experience.

3) The overcrowding problem is frequently handled by closing the unit to low risk deliveries.

4) The demand for certain hospital obstetrical units can be linked to increases in density of population in a geographic area, as well as, differences in policies and procedures relating to observers being present at deliveries and caesarean sections.

5) In addition to overcrowding...the nurses at the Health Sciences Centre state that their unit (physical space) is not conducive to provision of optimal care.

6) Nurses working in high risk units and community based hospitals believe community hospitals play a vital role in providing services to low risk mothers who desire a minimum amount of medical and technical intervention.

7) Nurses believe that regionalization of obstetrical services in Winnipeg has gone far enough.

8) Nurses are recommending obstetrical units in community based hospitals be upgraded to ensure adequate anaesthetic and obstetrician coverage to deal with unexpected problems during deliveries.

9) To aid in reducing the demand for obstetrical services where early discharge programs have been established, such as at St. Boniface, there must be adequate support and follow-up by public health nurses.

10) Nurses state there appears to be a difference of opinion in what encompasses "optimum care". Lack of input from nurses working in obstetrical units, when revisions to maternal/child care are planned, is a large part of the problem.

In discussion, the M.O.N.A. delegates clarified that they "...do not want low risk units to close..too many low risk moms are admitted to high risk centres because specialized services are not available at the low risk centres". Community hospitals should continue to provide services for low risk obstetrics but these units should be upgraded to ensure adequate anaesthetic and obstetrician coverage. Low risk patients are being admitted to high risk centres because of availability of supports. Obstetricians are dictating where deliveries take place. There is a need for cross training to improve skill levels of nurses in community hospitals.

UNIVERSITY OF MANITOBA - FACULTY OF MEDICINE

The representatives of the Faculty of Medicine identified six concerns as follows which, in their perspective, need addressing:

1) **DEMAND.** The projected fall in demand has not occurred. It is now anticipated that there will not be a decrease in births and in Winnipeg there will continue to be an increase. Consumer demand has changed with quality of service and ambiance of the birthplace both having a major impact. Patients are playing an increasingly active role in deciding where they should deliver . They are requesting and expecting anaesthesia and specialist neonatal care but simultaneously demanding a more holistic, less technical family centred setting.

2) **MANPOWER.** Insurance costs for family physicians doing obstetrics will probably reduce their numbers. At the same time the number of consultant obstetricians entering the profession is decreasing. The role of midwives has to be developed. There is a place for midwives within the medical model. Manitoba should not follow a model where midwifery is allowed to be entirely separate from and runs parallel to, the traditional medical practice.

3) **STANDARDIZATION OF ASSESSMENT.** A routine, organized screening and ultrasound program should be developed. All patients should be assessed.

4) **RURAL/URBAN INTERACTION.** Interaction with urban centres should increase in order to improve rural access to asssessment programs. Tertiary care centres should inter-relate with rural centres and outreach programs such as the St. Boniface Hospital Ultrasound Program, should be encouraged.

5) **NATIONAL CENTRE.** Winnipeg should be designated a national centre for areas of special expertise such as immune acquired anaemias.

6) **EQUIPMENT PURCHASE STANDARDIZATION.** Existing equipment is a collage of different kinds. Standards and a network of systems need to be established. Technology now exists to transmit, for example, heart rate monitor information from remote locations to tertiary care centres for interpretation with almost instant advice passed back to physicians on the scene.

In response to questions, it was indicated that obstetricians have a national position on the question of midwives, namely, that midwives are favoured for low risk obstetrics in a team approach with almost instant access for help if difficulties are encountered. Also, the optimal number of deliveries for one institution was recommended at 4,000 to 5,000 as a maximum and 1,200 as a minimum.

DEPARTMENT OF HEALTH - RESEARCH AND PLANNING DIRECTORATE

The Research and Planning Directorate made a presentation to the Task Force on potential for further reductions in post partum length of stay (potential for expansion of early obstetrical discharge programs). Conclusions are that:

1) Current average length of patient stay for obstetrics of 3.3 days could be reduced to 2.4 days for 7,000 cases considered "eligible" for an early discharge program (out of Winnipeg's total 11,700 deliveries of this study). But there is a "national" trend of decreased stay now and expected to continue due to the desire of well mothers (even without further investment in early discharge programs) to be at home.

2) Expansion of early discharge programs would not lead to reduced overall costs because the cost of increased community supports required would not be offset by reduced hospital stay which would save only the "hotel" costs of days at the end of a stay which are the least expensive component. It would not be possible to "save" sufficient hospital days to close an entire post partum ward. With lesser bed "savings" even minor staffing reductions would likely not be managed; at best some staff might be re-directed to "other hospital things".

APPENDIX VII

MANITOBA DEMOGRAPHIC TRENDS
THE POTENTIAL FOR REDUCED WINNIPEG DELIVERIES

The Task Force contracted with the Manitoba Bureau of Statistics to forecast the number of deliveries Winnipeg should prepare to provide for in the future. The Bureau's report entitled "Manitoba Demographic Trends 1986 - 2011" was presented to the Task Force in November, 1989. The report's information and forecast of deliveries was updated in November, 1990, and this update is summarized in the attached Schedule III.

The report is an extensive analysis and projection that incorporates the cohort population projection model of the Bureau with age specific fertility rates, by Manitoba's regions, into projections of future deliveries. The effects of high birth rates of Registered Indians and rural Manitobans delivering in Winnipeg is taken into account.

There has been a significant change to the Manitoba "fertility rate" in the past two decades as follows:

MANITOBA FERTILITY RATE

1971 - 2.54	1981 - 1.86
1972 - 2.38	1982 - 1.84
1973 - 2.24	1983 - 1.87
1974 - 2.18	1984 - 1.86
1975 - 2.09	1985 - 1.88
1976 - 2.02	1986 - 1.88
1977 - 1.96	1987 - 1.86
1978 - 1.91	1988 - 1.90
1979 - 1.88	1989 - 1.99
1980 - 1.84	

The November, 1989, report projected Winnipeg deliveries assuming a constant fertility rate. Now, with 1989 information added, it appears a slight upward trend may be establishing. The effect becomes a little more clear on examining recent age-specific fertility rates for Manitoba and Winnipeg as follows:

AGE SPECIFIC FERTILITY RATES (BIRTHS PER 1,000 FEMALES)

Mother's Age	Total Manitoba				Winnipeg			
	86/87	87/88	88/89	89/90	86/87	87/88	88/89	89/90
15-19	38	38	40	42	29	33	35	38
20-24	95	93	95	101	70	71	75	83
25-29	131	131	131	132	118	114	116	114
30-34	83	80	83	89	87	79	85	89
35-39	24	26	27	30	24	30	30	32
40-44	4	4	5	4	4	4	5	4
45-49	0	0	0	0	0	0	0	0
Total Fertility Rate	**1.882**	**1.861**	**1.900**	**1.990**	**1.666**	**1.654**	**1.735**	**1.799**

	Total Fertility Rate	Total Fertility Rate Winnipeg
Three Year Average:		
86/87 thru 88/89	1.890	1.670
87/88 thru 89/90	1.917	1.729
Percent Change	+1.43%	+3.53%

The attached Schedule III reconstructs the projection of the Bureau's report by showing the effect of a slight increase (3.53%) to the Winnipeg fertility rate in addition to the original projection based on a constant fertility rate. For the years 1990 through 1996:

- o the cohort population model of the Bureau, which tracks a decreasing number of females moving through the child-bearing ages, suggests there should be a decrease to Winnipeg deliveries;
- o the slight increase in fertility rate experienced in 1989 offset the expected reduction and Winnipeg deliveries increased in 1989;
- o deliveries in Winnipeg increased again in 1990 suggesting the 3.5% calculation of a fertility rate increase (based on a three year average) is not sufficiently accurate.

Obviously, more time is needed to allow the expected trend to establish itself and to measure its extent through to the year 1996 and beyond.

Recent announcements about increased immigration Canada will allow have raised questions, but the potential effect on increased deliveries in Winnipeg is proportionately negligible. Historically, Manitoba has received between 3 and 4% of such immigration, about half are female and about half of the females are in the child-bearing ages. If there would be a 50,000 increase in Canadian immigration this would add between 20 and 50 deliveries to Winnipeg based on historical measurements. This is relatively insignificant and random variation to birth rates can account for a lot more.

SCHEDULE III

ACTUAL AND PROJECTED NUMBER OF BIRTHS

	Births to Winnipeg Residents		Births Occurring in Winnipeg (2)		Manitoba Births	
Actual						
1987	8,952		11,688		17,333	
1988	9,327		12,015		17,594	
1989	9,588		12,136		17,610	
Projected	Constant Fertility	Slight Increase (1) to Fertility	Constant Fertility	Slight Increase (1) in Fertility	Constant Fertility	Slight Increase (1) in Fertility
1990	8,990	9,310	11,530	11,970	16,800	17,040
1991	8,790	9,100	11,270	11,700	16,600	17,310
1992	8,560	8,860	10,970	11,390	16,400	16,630
1993	8,320	8,610	10,670	11,070	16,100	16,330
1994	8,080	8,360	10,360	10,750	15,800	16,030
1995	7,840	8,120	10,050	10,440	15,600	15,820
1996	7,610	7,880	9,760	10,130	15,300	15,520

(Continues at 1996 level to approximately 2010)

(1) Calculated at 3.53% for Winnipeg and 1.43% for Manitoba

(2) Projected births occurring in Winnipeg are calculated from 1987 to 1989 data. The ratio of occurrence to residence is 1.286. $\left(\frac{11,688 + 12,015 + 12,136}{8,952 + 9,327 + 9,588} = 1.286\right)$

APPENDIX VIII

CONSOLIDATION OPTIONS FOR WINNIPEG

The 1973 report of the "M.M.A. Study Committee on Regionalization of Obstetrical Services and Distribution of Obstetrical Beds in Winnipeg and the Province of Manitoba" (better known as the Peddle Report) is a remarkably forward-looking document. The report discusses six consolidation options for Winnipeg, only two of which (Option III and Option VI) were supported. These two options remain pertinent today.

Option III was to consolidate Winnipeg's obstetrical services into four hospitals, with two community hospitals providing lower risk services and the two teaching hospitals providing a full range of care including perinatal intensive care. The report describes Option III as "...close to the ideal situation and may be a reasonable compromise."

Option VI was to provide the full range of obstetrical services, including perinatal intensive care, at the two teaching hospitals and to phase out obstetrical services at community hospitals providing less than 1,000 deliveries per year. The remaining community hospital obstetrical services would provide "community perinatology" meaning a lower risk service. The report recommended Option VI as being "...economically feasible at this time."

Finally, the Task Force warns against making the assumption that consolidation of the three Winnipeg community hospital obstetrical services may produce cost savings. It is likely that consolidation would permit additional perinatal services and staffing patterns more able to provide for higher risk deliveries within current dollars, but it will not be possible to also extract savings.

The space vacated, in the hospitals where the obstetrics services would close, would soon fill with other services requiring funding. Also, there would be additional "indirect support costs" required for the consolidated service and these would not be offset by extractable savings in indirect costs at the hospitals where obstetrics would be discontinued.